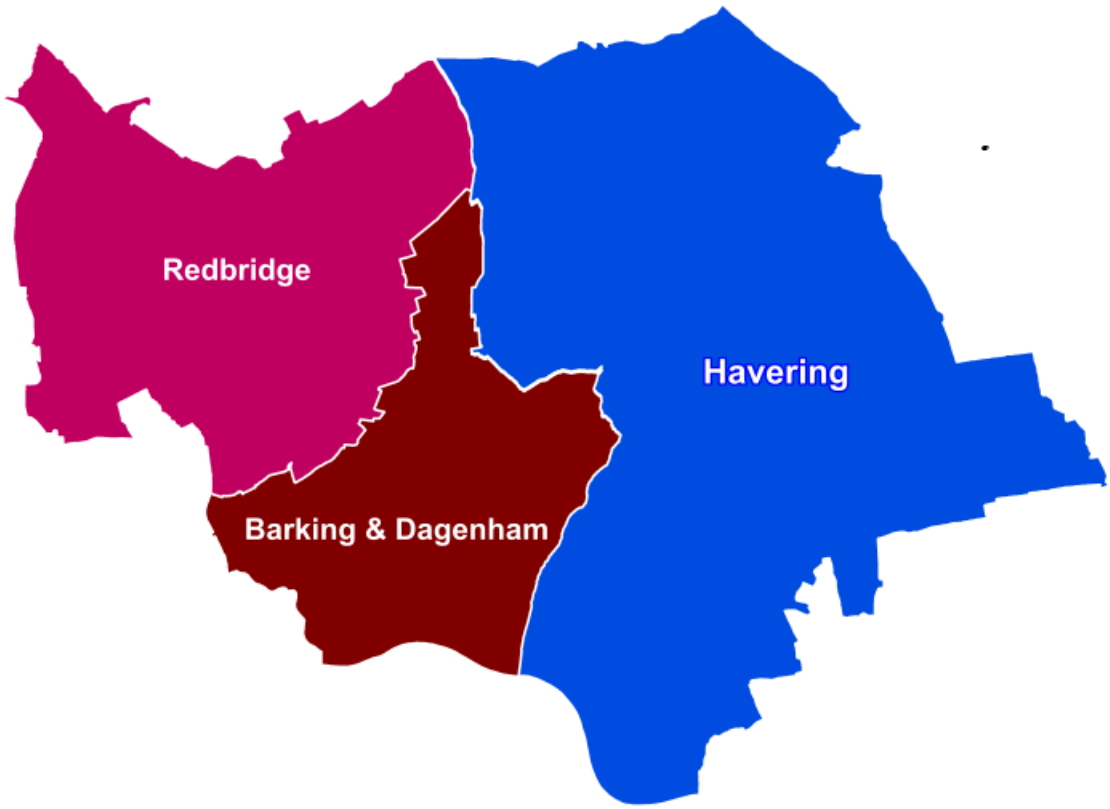
Barking & Dagenham, Havering and Redbridge Joint Strategic Needs Assessment Profiles

Recommendations

London Borough of Havering



October 2022

1. Current health outcomes of Havering residents

Recommendation 1: All partners should participate in borough level HWBs and take the opportunity to ensure there are robust plans in place regarding all four pillars of the population health model.

Recommendation 2: Plans regarding integrated health and social care services (pillar 4) should give the same priority to conditions resulting in ill health and disability as for conditions causing premature death.

Recommendation 3: All partners within the developing integrated care system must give prevention and treatment equal priority if they are to succeed in improving health, narrow inequalities and provide high quality, affordable health and social care services.

Recommendation 4 Plans regarding the recovery of health and social care services from the pandemic are essential but must not divert from the commitment to adopt a population health management approach that seeks to prevent ill health and pre-empt crises by the timely, proactive offer of support, care and effective treatments to an empowered and informed population.

2. Pillar 1: The wider determinants of health

Recommendation 5: Ensure Councils / NHS providers work with the DWP to offer residents excluded from employment due to disability and / or ill health including mental illness the opportunity to gain confidence, skills, work experience and ultimately secure employment.

Recommendation 6: Consider the impact of working from home on the existing workplace health offer to employees and advice provided to local businesses.

Recommendation 7: Partners must work together to mitigate the worst harms of street homelessness and help those affected with the ultimate aim of enabling them to maintain suitable permanent accommodation.

Recommendation 8: The wider partnership should consider the opportunities afforded by regeneration in all 3 BHR boroughs to offer affordable housing to attract and retain workers in hard to recruit professions.

Recommendation 9: Encourage health and social care professionals and patients / residents to consider the extent to which problems with employment, poverty, housing etc. are the underlying cause and / or exacerbate a presenting health issue and therefore might benefit from social prescribing[1] in addition to or instead of the tradition medical response.

[1] https://www.kingsfund.org.uk/publications/social-prescribing

Recommendation 10: Strengthen social prescribing as an effective alternative / adjunct to existing health and social care options. This should include action to identify and strengthen community capacity and self-help options as well as an effective signposting function and bring together NHS, council and CVS stakeholders.

Recommendation 11: Encourage councils, NHS providers, colleges etc. to become 'anchor institutions' within the BHR patch maximising the contribution they make to the local community over and above the direct provision of services.

Recommendation 12: Encourage all partners to adopt a Health in All Policies approach that takes into consideration health and wellbeing impacts in decision-making, including on the social determinants of health to maximise the wellbeing of residents.

Recommendation 13: Strengthen community resilience through continued partnership with the VSC. This includes building upon and mapping existing VCS capabilities, identifying gaps in community support and providing opportunities for skills development.

3. Pillar 2: Lifestyles and Behaviours

Recommendation 14: Focus additional efforts in disadvantaged communities and / or cohorts known to have high prevalence of smoking e.g. people with mental ill health.

Recommendation 15: Ensure that smokers who wish to quit can access face-to-face counselling support and pharmaceutical aids, including prescription only medication where clinically indicated smokers to quit.

Recommendation 16: Actively promote e-cigarettes to smokers as an effective quitting aid and a safer alternative to continuing to smoke.

Recommendation 17: Contribute towards the aspiration of a smoke free society by 2030 e.g. by continuing the de-normalisation of smoking in public spaces and homes; minimising the recruitment of new smokers through work with schools, rigorous enforcement of age-related sales regulations and minimising access to cheap smuggled or counterfeit tobacco.

Recommendation 18: Actively promote existing food and financial support mechanisms to low income households and households with children e.g. Havering Community Hub food pantry, free school meals, school holiday meal scheme, Healthy Start scheme etc.

Recommendation 19: Ensure that there is a comprehensive whole system approach to tackling obesity across BHR as a whole with additional efforts aimed at supporting groups known to have higher prevalence of obesity.

Recommendation 20: Partners should work to:

- increase participation in drug and alcohol treatment, particularly the latter, with additional efforts aimed at supporting those who are more socially deprived

- improve the offer to people with drink and drug dependency and additional mental health problems
- effectively support people with drink and drug problems who are street homeless
- reduce and prevent harm to children and families arising from parental drink and drug problems.

4. Pillar 3: The Places and Communities in Which We Live.

Recommendation 21: Partners should collaborate to reduce greenhouse emissions and mitigate the harms caused, ensuring that climate change is considered in every policy and decision.

Recommendation 22: Partners should collaborate to reduce air pollution, risks and health inequalities and ensure the impact on air pollution is considered in every relevant decision.

Recommendation 23: Partners should collaborate to raise public understanding and awareness of current local levels of air pollution – the 'air pollution forecast' and encourage residents to adjust their behaviour accordingly, taking into account any health problems that might put them or their family at particular

Recommendation 24: The Local Authority to work with partners to expand the active transport infrastructure in the borough. The health and social care system to advise residents of the health benefits of active travel whenever

Recommendation 25: All partners to facilitate the shift to electric vehicles including their own fleet.

Recommendation 26: Councils to make use of the powers available to create a healthier offer on our high streets, prioritising disadvantaged areas with the unhealthiest offer, and taking into consideration the views of the local community.

Recommendation 27: Ensure plans and policies shaping regeneration and housing growth e.g. borough level Local Plans serve to build healthier communities not simply additional housing. A formal health impact assessment of the Local Plan may help in this regard.

Recommendation 28: Boroughs, working with developers, should put in place processes to share learning from the healthy new town project at Barking Riverside.

Recommendation 29: Ensure that the housing needs of residents with specific needs e.g. relating to frailty, mental illness, physical and learning disabilities etc. are an integral part of plans for housing growth and regeneration.

Recommendation 30: Consider if / how key worker housing might be made available to attract hard to recruit health and social care professionals into the BHR patch.

Recommendation 31: Building on regeneration plans in the three boroughs; develop an effective approach to promote the benefits of living in Barking, Havering and Redbridge as part of collective effort to fill hard to recruit health and social care vacancies.

Recommendation 32: Health and Social Care Partners should participate in Community Safety Partnerships and contribute to the delivery of agreed plans and strategies.

Recommendation 33: The partnership must consider the needs of digitally excluded communities whenever it seeks to improve access to service by digital means.

Recommendation 34: Partners, working with the community, should agree the need for action and how best to go about strengthening social networks and community capacity, prioritising areas with new housing developments, high population churn and significant disadvantage.

Recommendation 35: Partners to consider and respond to the needs of employees who, post-pandemic, routinely work from home to ensure their physical and mental health.

Recommendation 36: Partners should work to reassure the great majority of residents who may have shielded during the pandemic that vaccination, and antivirals for some patient groups, offer excellent protection against serious illness and hence the harms of continuing to 'self-shield' outweigh the benefits to physical and mental health to be gained from re-entering their community.

5. Pillar 4: Integrated Health & Social Care

5.1 Antenatal and Maternity

Recommendation 37: Enhance continuity of carer (CoC) ensuring as many women as possible receive midwife-led CoC, initially prioritising those identified as most vulnerable and high risk.

Recommendation 38: Strengthen personalised care and choice; increase the proportion of women with a personalised care plan, initially prioritising disadvantaged and vulnerable women, whilst offering all women information and choice on place of birth.

Recommendation 39: Continuously improve maternal safety including: by full implementation of the second version of the Saving Babies' Lives Care Bundle; and by working with Public Health to help expectant mothers to stop smoking to meet the national ambition to halve the rate of stillbirths, neonatal deaths, maternal deaths, and intrapartum brain injury by 2025.

Recommendation 40: Improved quality of postnatal care for all women including enhanced support to vulnerable women (e.g., perinatal mental health, drug and substance misuse) and focusing on infant feeding.

Recommendation 41: Improve access to domestic violence support to all women accessing maternity services through the introduction of an early support and referral scheme for identified victims

5.2 Children and young people

Recommendation 42: Commissioners / providers should regularly review universal services e.g. health visiting, community paediatrics, therapies etc. to ensure capacity is adequate given the pace and scale of change in the CYP population in recent years.

Recommendation 43: The children and young people population is more diverse than the population as a whole and becoming more diverse. All partners should ensure that consideration of culture and language is integral to the development of all services and particularly services for CYP.

Recommendation 44: Lessons learned through the Child Death Review process should be shared at least annually with commissioners and providers of maternity and children's services to inform decisions regarding priorities for action.

Recommendation 45: Ensure opportunities to maximise awareness and uptake of free preschool education and childcare are taken e.g. via regular contacts with health professionals including midwifery, health visiting and with general practice and Local Authority Early Help teams/Children's Centres.

Recommendation 46: Maximise uptake and face-to-face delivery of the 5 mandated health and development checks for children aged 0- 5. Increase joint assessments by early years settings and health visitors at age 2 – 2 ½ yrs.

Recommendation 47: Ensure that anonymised aggregate data from the ASQ3 are available to inform health service planning and interventions to improve school readiness.

Recommendation 48: Partners should work together to improve the proportion of children achieving at least the expected level across all learning goals, and a good level of development. Consider additional action to reduce inequalities associated with gender and disadvantage.

Recommendation 49: As part of their anchor institution role, health and care providers should contribute to wider efforts to build aspiration and educational achievement particularly in disadvantaged and / or otherwise vulnerable groups e.g. through outreach to schools and career fairs; offering workplace experience; apprenticeships; career paths from less skilled, lower paid roles into better paid, professional health and social care roles etc.

Recommendation 50: Boroughs to lead a whole system approach to obesity; health and care partners to offer Tier 2 and Tier 3 weight management services for CYP and their families.

Recommendation 51: Ensure that programmes to improve digital connectivity are supported by associated education and awareness of the health impacts of cyberbullying and screen addiction.

Recommendation 52: Encourage and support early years settings and schools to maximise the health and wellbeing benefit to children and young people in their care through participation in the relevant HEYL/HSL scheme or similar.

Recommendation 53: Health and care partners should work with schools to provide support to pupils at risk of exclusion.

Recommendation 54: Put in place processes to share learning between boroughs, and between health and care partners about how to improve emotional wellbeing and mental health and better protect children from harm, including the joint working between EIF and Barking & Dagenham.

Recommendation 55: Health, social care and education to periodically review their joint approach to prevent unplanned pregnancy and support teenage parents.

Recommendation 56: Health and care partners must actively contribute to collective efforts to reduce serious youth violence and gateways to youth crime; as part of comprehensive efforts to minimise exposure to adverse childhood experiences.

Recommendation 57: Review the delivery of childhood immunisation in BHR and develop plans to increase uptake to levels necessary to achieve herd immunity**.**

Recommendation 58: Health and care partners, Early Years settings, children's centres, the VCS and parents' representatives to work together to understand how best to meet the health care needs of families with children, improving patient experience and making best use of limited A&E capacity.

Recommendation 59: Providers to prioritise mandated early years checks as part of wider efforts to recover from the impacts of Covid

Recommendation 60: All partners to prioritise and consider how best to implement plans developed to improve asthma care in BHR.

Recommendation 61: CYP and MH transformation Boards should work to: -

- Increase CAMHS capacity and strengthen links with other providers
- Develop the capacity and capability of professionals in universal services including health visiting, school nursing general practice and schools to support children with mental health problems and their families
- Support children and their families to be more resilient

Recommendation 62: ICS partners to:-

i) consider how best to report attendances for self-harm in CYP;
ii) ensure that NICE guidance for psychosocial assessment after hospital attendance for self harm is implemented.

Recommendation 63: CYP transformation board to champion improved partnership working to better meet the needs of CYP with SEND including joint reviews and options

for Pan BHR commissioning to facilitate best use of scarce clinical resources and enable provision of care closer to home.

Recommendation 64: All partners must participate in safeguarding arrangements and ensure all staff working within the ICS are clear on thresholds and pathways for raising and acting on safeguarding concerns.

Recommendation 65: Health and care partners to consider how they can support care experienced young people into employment as part of their wider 'anchor institution' role

5.3 Adult Mental Health

Recommendation 66: Investigate whether groups at higher risk of mental ill health are proportionally represented at all levels of mental health service provision.

Recommendation 67: Raise public awareness of mental ill health, tackle associated stigma and strengthen personal resilience, including by making use of 'Every Mind Matters' resources and self-help aids; giving particular consideration to groups who appear less likely to seek help such as LGBTIQ+ and ethnic minority residents, and older people.

Recommendation 68: Promote the Making Every Contact Counts (MECC) approach by providing training to front facing staff across the wider partnership to promote awareness of mental health issues including stigma, suicide prevention and the benefits of Talking Therapies.

Recommendation 69: Improve understanding of public perceptions of Talking Therapies and barriers to access and use the insight gained to improve how IAPT is promoted and delivered to maximise participation and successful completion.

Recommendation 70: Continue to develop the capacity and capability of primary care to manage patients with common mental disorders and integrate consideration of mental health into the management of other care groups known to be at high risk of mental health problems.

Recommendation 71: Develop partnerships between primary care, specialist mental health services, other statutory services and the VCS at locality level to provide holistic support addressing the wider determinants as well as health and social care needs of people with mental health problems. An effective social prescribing function will assist patients to engage with relevant support.

Recommendation 72: Improve and increase joint working between mental health services and drug and alcohol services to improve outcomes for patients with co-occurring substance/alcohol misuse and mental health conditions.

Recommendation 73: Mental health and substance misuse services to work with relevant Council services to effectively outreach to and support the street homeless.

Recommendation 74: Review arrangements for those in contact with the criminal justice system, including ex-prisoners and their access to mental health services, and mental health service provision for offenders served with community orders, particularly for those subject to Alcohol Treatment Orders and Drug Rehabilitation Requirements

Recommendation 75: MH services should audit re-admissions to identify the underlying causes of re-admission and whether improvements could be made as part of planned discharge, and ongoing treatment and support (including support from local authority housing teams).

Recommendation 76: Statutory services across BHR should be encouraged to offer people with health problems including mental health problems the opportunity to gain employment.

Recommendation 77: Review the management of patients in crisis ensuring there is adequate place of safety provision given population growth and increasing complexity of needs. Investigate where interventions might have previously prevented escalation to crisis and use the lessons learned to improve mental healthcare.

Recommendation 78: Improve the management of physical health of patients with SMI; ensure all get an annual health check and, through joining up initiatives across the system, improve effectiveness of support available to assist with lifestyle change, starting with smoking.

Recommendation 79: Ensure there are comprehensive strategies/plans to prevent suicide. These should include (a) support to people bereaved by suicide and (b) systems to record episodes of self-harm and for subsequent follow up in the community.

Recommendation 80: Monitor suicides in real time to identify trends and use the insight to inform preventative action as needed.

5.4 Cancer

Recommendation 81: Work with young people, parents and schools, as well as local providers to maximise uptake of HPV for boys and girls.

Recommendation 82: Continue to work to increase uptake of: cervical screening by offering extended hours in general practice; bowel screening with the roll out of FIT[2] testing for diagnosing colorectal cancer; and breast screening

Recommendation 83: Undertake a deep dive/equity audit to understand which populations are not taking up screening and support a programme of community

[2] https://www.cancerresearchuk.org/health-professional/screening/bowel-screening-evidence-and-resources/faecal-immunochemical-test-fit#FIT2

engagement working with those identified as less likely to participate in screening programmes to increase uptake.

Recommendation 84: To undertake an audit to assess the impact of Covid-19 on Cancer screening and service delivery including emergency presentations post-pandemic

Recommendation 85: Continue efforts to raise awareness of signs and symptoms of cancer with the public and healthcare professionals.

Recommendation 86: Continue to deliver sustained Cancer Waiting Time targets and implement and thereafter achieve the new 28-day Faster Diagnosis Standard (FDS)3

Recommendation 87: Implement the national optimal cancer pathways[4].

Recommendation 88: Deliver personalised care for all cancer patients, resulting in improved patient experience and outcomes; specifically embed stratified pathways[5] for prostrate, breast and bowel cancer patients.

Recommendation 89: Work towards a step-change in patients' and clinical professionals' understanding of cancer, with it being thought of as a Long-Term Condition.

5.5 Long Term Conditions

Recommendation 90: BHR should review the care pathway and provision of support for patients found to be at high risk of LTCs following an NHS Health Check (or other identification route) to ensure that:-

- Behaviour change support is effective, high quality and in line with best practice guidelines. This should include reviewing whether support is culturally appropriate for each borough's communities, with a focus on contributing to reductions in health inequalities by ethnicity and deprivation
- Treatment is likewise effective, high quality and in line with best practice guidelines.

Recommendation 91: Each BHR borough should review the current service delivery model and approach to increasing the offer and uptake of NHS health checks and develop a robust action plan for improvements in uptake, particularly among those at greatest risk of poor health. Key opportunities to explore should include the accessibility of Health Checks appointments by time and geography, the role of PCNs and exploring the potential for delivery of workplace-based programmes.

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[3] https://www.england.nhs.uk/cancer/early-diagnosis/

[4] http://uklcc.org.uk/wp-content/uploads/2019/10/01-UKLCC-Pathways-Matter-Report-Final.pdf

[5] https://www.england.nhs.uk/wp-content/uploads/2016/04/stratified-pathways-update.pdf

Recommendation 92: To review the processes for analysis and reporting of key local data on preventative interventions to support local Public Health teams in improving delivery. This should include both the Health Check and National Diabetes Prevention programmes. There should be a focus on improving the granularity of data, both by geography (in particular by Primary Care Networks) and inequalities by ethnicity, deprivation and age, as well as regular reporting of data on invitation, uptake and outcomes.

Recommendation 93: BHR should review the local approach to maximising participation in the National Diabetes Prevention Programme and develop an action plan for improved uptake and outcomes. This should include actions to ensure that the NDPP is culturally appropriate for the different communities of BHR to reduce inequalities by ethnicity and deprivation.

Recommendation 94: BHR should review and amend where necessary the current approach to the delivery and monitoring of diabetes care to ensure that all effective care is consistently provided.

Recommendation 95: BHR should explore opportunities to expand the target populations for NHS Health Checks and the NDPP beyond the statutory minimum (currently 40-74 years for Health Checks and 35+ for the NDPP) to increase the proportion of people with diabetes that are diagnosed and can be offered effective prevention. In addition, BHR should develop actions to increase uptake by under-served populations (such as homeless residents).

Recommendation 96: BHR should review current levels of preventable mortality and surgical procedures linked to LTCs, to understand in detail differences across the three boroughs. A robust action plan should be developed to reduce preventable mortality and procedures.

Recommendation 97: BHR should conduct a review of the current provision of prevention and care to those with multiple conditions and develop a robust action plan for improving local care pathways across all three boroughs to reduce levels of preventable ill health, morbidity and mortality.

Recommendation 98: Consider commissioning of further services for those with long Covid, based on learning from newly commissioned services in BHRUT. These should include dedicated support services and self-management, for example mobile apps, community exercise programmes and peer support groups.

Recommendation 99: Borough partnerships should work with primary care clinicians and directly with the public to raise awareness of long COVID, opportunities for self-care and appropriate referral for specialist assessment

5.6 Older People & Frailty

Recommendation 100: Build on the effective partnerships established during the pandemic to maintain and further improve uptake of flu and covid vaccines.

Recommendation 101: Recognise heightened awareness of the benefits of vaccination amongst older age groups and (re-)check status regarding pneumococcal and zoster vaccines.

Recommendation 102: Maintain efforts to further increase the completeness of dementia diagnosis, and improve access to the information and support for patients and their families

Recommendation 103: Support efforts to tackle social isolation in general, but particularly amongst older residents, as part of wider efforts to improve the mental health of older people.

Recommendation 104: Services should be designed so that older people's needs can be met, including mental health and dementia.

Recommendation 105: Ensure the BHR Falls prevention pathway is consistent with national guidance and equitably implemented according to need.

Recommendation 106: Refer older adults with functional loss, transition towards frailty or fear of falls resulting from deconditioning to appropriate rehabilitation services.

Recommendation 107: Ensure that patients at risk of frailty are systematically identified, using population health management approach; effectively supported by the local partners to stay well; or receive urgent additional help in times of crisis.

Recommendation 108: Ensure that the BHR Older People and Frailty Prevention offer currently under development is comprehensive, addressing socio-economic and behavioural risk factors and the early identification and management of modifiable conditions.

Recommendation 109: Ensure that there is a systematic approach of reviewing patients with Multimorbidity and frailty that includes a medication review to maximise the benefits of medications and minimise side effects.

Recommendation 110: Further improve the reablement offer in all three boroughs to maximise the proportion of patients who return home and stay home after admission to hospital.

Recommendation 111: Develop plans to implement the Enhanced Health in Care Homes (EHCH) model to all care homes in BHR.

Recommendation 112: Strengthen end-of-life care to increase the proportion of people who are supported to die with dignity in their usual place of residence.

5.7 Planned (non-urgent) Care

Recommendation 113: Support implementation of plans developed by the BHR Planned Care Transformation Board

5.8 Urgent and Emergency care

Recommendation 114: Support plans developed by the BHR Urgent Care Transformation Board, and:

- encourage clinicians and patients to make appropriate use of alternatives to ED referral and attendance, including self care
- support residents to stay well longer and ensure they receive effective preventative and / or primary treatment to minimise the need for urgent and emergency care